

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/15/2015
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey Date: January 15, 2015</p> <p>Facility Number: 000038 Provider Number: 155095 AIM Number: 100274830</p> <p>Survey Team: Martha Saull, RN TC Julie Call, RN Sue Brooker, RD Virginia Terveer, RN</p> <p>Census Bed Type: SNF: 19 SNF/NF: 144 Residential: 24 Total: 187</p> <p>Census Payor Type: Medicare: 21 Medicaid: 107 Other: 59 Total: 187</p> <p>Heritage Park Commons was found to be in compliance with 410 IAC 16.2-5 in regard to the Initial State Residential Licensure Survey.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE